

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-016974

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

FILED MAY 1 1962

Primary Registration District No.

1003

Registrar's No.

4338

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Indiana b. COUNTY Clark	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN Sellersburg Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 881 E. Utica Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MYRTLE McCoy KRANZ		4. DATE OF DEATH Month Day Year APRIL 23 1962	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/20/1907
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 54 IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) Clark Co., Ind.		12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME Charles McCoy		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Jacob Kranz		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Jacob Kranz, Sellersburg, Ind.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLI Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) THROMBOSIS OF RIGHT FEMORAL VEIN DUE TO (c) CARCINOMA OF BREAST WITH METASTASES		INTERVAL BETWEEN ONSET AND DEATH 1 DAY 2 WEEKS 19 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. 170X <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from APRIL 14, 1962 to APRIL 23, 1962 and last saw her/him alive on APRIL 23, 1962 Death occurred at 5:28 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) C. O. Vermillion, M.D.	
22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 4/23/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4-26-62	23c. NAME OF CEMETERY OR CREMATORY Sellersburg Cemetery	23d. LOCATION (City, town, or county) (State) Sellersburg, Ind.
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd.		25. DATE RECD. BY LOCAL REG. APR 26 1962	
26. REGISTRAR'S SIGNATURE Carl Smith, M.D.			

USE BLACK INK
OR
TYPEWRITER RIBBON

OCT 9 1962

JUN 11 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Stanley H. Dixon

Licensed Embalmer No. 4193

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.